Expedited Partner Therapy: Innovative Health Policy Reduces STIs and Prevents Infertility

By Ann Kelly [1]
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Expedited partner therapy allows clinicians to treat the sex partners of patients diagnosed with chlamydia or gonorrhea prior to evaluating the partners, under certain conditions. Innovative and cost-effective, expedited partner therapy is legal in 22 states and is an increasingly important state prevention policy to reduce infections and their consequences, including infertility.

Book of the States, 2010: Chapter 9 [2]

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Table A: Prevention of Sexually Transmitted Infections: Expedited partner therapy legal status, STI prevention funding, and rates of chlamydia and gonorrhea infections by race/ethnicity: Download in Excel [4] or PDF [5]

In August 2009 Illinois joined 21 other states that endorse an innovative approach to control sexually transmitted infections known as expedited partner therapy, when Gov. Pat Quinn signed Senate Bill 212. The bill was strongly supported by a coalition of health care organizations and passed with minimal opposition in the legislature. 1

By approving expedited partner therapy, states allow partners of patients diagnosed with chlamydia or gonorrhea to receive antibiotics without being seen by a medical provider. Expedited partner therapy helps patients diagnosed with sexually transmitted diseases avoid reinfection by getting treatment for their sexual partners who are either unable or unwilling to see a medical professional. Expedited partner therapy can be accomplished a few different ways. When patients are diagnosed, medical providers can give them antibiotics they can take to their sexual partners. In other situations patients are given prescriptions for their partners, or patients tell partners where to obtain antibiotics from a pharmacy or public health program. The treatment used for partners is generally a one-time dose of antibiotic with low potential for allergic and other adverse reactions. In all cases, patients should also receive written instructions for their partners on how to take the medication, and health information including how long to abstain from sex after treatment and encouragement to seek evaluation by a health care provider.

Expedited partner therapy provides clinicians with an additional tool in treating sexual partners in complicated situations. Patients can be unwilling to give the names of their partners to health officials. Since the diseases frequently occur without symptoms, partners may refuse to see a doctor
because they think they are not infected. Partners also may lack health coverage or access to a
trusted health provider, or they may have concerns about confidentiality or cost of such a health care
visit.

Expedited partner therapy was first endorsed by public health officials to supplement traditional
approaches of contacting and treating sexual partners. It has become a more important tool because
of the large number of people infected with these curable infections, the reluctance of patients and
medical providers to make referrals to health officials, and the financial constraints limiting health
departments’ ability to contact the sexual partners of those with chlamydia and gonorrhea. When
used appropriately, expedited partner therapy typically has higher success in getting sexual partners
treated compared to other patient referral approaches. California health officials recently compared
expedited partner therapy success to other approaches used in family planning centers. They found
that although a majority of patients used traditional partner referral with only a 40 percent success rate,
patient-delivered partner therapy (California’s version of expedited partner therapy) was used
for one in five patients and achieved a 77 percent success rate. 3

Disparities and Preventing Infertility and Other Consequences

Chlamydia is the most common reported sexually transmitted infection in the U.S., and the Centers
for Disease Control and Prevention estimates that nearly 3 million people are newly infected each
year. New gonorrhea infections are less common, occurring in about 700,000 Americans annually, and
like chlamydia, it is curable and preventable. Since both of these sexually transmitted infections often
occur without symptoms, about half of those who are newly infected each year are undiagnosed and
untreated, and can suffer the consequences of the diseases, including infertility. 4 For specific state
information, see state profiles at http://www.healthystates.csg.org (6).

Teenage girls have the highest number of reported infections, accounting for about 25 percent of the
five most common sexually transmitted infections. 6,7 Reported rates of chlamydia among African-
American women are eight times higher than among white women, and three times higher than
among Hispanic women. Although gonorrhea infections occur less often, rates for this infection are 16
times greater among African-American women than their white counterparts. For both infections, the
highest rates in women occur in African-American females ages 15 to 19, followed by African-
American women ages 20 to 24; similar racial disparities exist among young males. Among American
Indian and Hispanic populations, teen girls and young women have chlamydia and gonorrhea infection
rates that are two to three times higher than white women. 8,9

About 15 percent of women with untreated chlamydia and gonorrhea can develop pelvic inflammatory
disease, which can lead to infertility and recurring chronic pain, and tubal pregnancy, a condition that
can be life-threatening to the mother. In addition, chlamydia infection increases a woman’s risk of
contracting HIV from a sexual partner. For pregnant women, chlamydia may lead to premature
delivery and can cause infection in their babies. 8,10 The CDC estimates that undiagnosed and
untreated sexually transmitted infections cause infertility in at least 24,000 American women each
year. The costs of treating these preventable conditions are significant for both public and private
health insurers, particularly in states requiring health coverage for infertility. Fifteen states mandate
some coverage for infertility treatment: Arkansas, California, Connecticut, Georgia, Hawaii, Illinois,
Maryland, Massachusetts, Montana, New Mexico, New York, Ohio, Rhode Island, Texas and West
Virginia. 8,12,13

To prevent these sexually transmitted infections and their complications, the CDC recommends
annual chlamydia testing and treatment for all sexually active females under age 26, as well as older
women with risk factors such as a new sex partner or multiple partners. Annual chlamydia testing of
sexually active young women has been recommended by the U.S. Preventive Services Task Force
since 1996. In addition, since 2000 the Healthcare Effectiveness Data and Information Set quality measures have included chlamydia testing statistics, both for commercial health insurance plans and Medicaid managed care plans. In spite of these recommendations, only about 40 percent of sexually active females enrolled in health plans were tested in 2007. The regional testing rates were highest in the Northeast (46 percent) and lowest in the South (37 percent), indicating that additional testing by U.S. health care providers is needed to reduce the preventable consequences of chlamydia infection among young women. Annual testing for gonorrhea in high-risk sexually active women also is recommended by the U.S. Preventive Services Task Force. Patients diagnosed with either infection are counseled to take antibiotics, and to encourage their sexual partners to be treated. Expedited partner therapy allows patients to actively participate in getting their partners treated and thus avoid becoming reinfected, and avoid resulting harmful effects such as infertility.

Legal Status of Expedited Partner Therapy

Expedited partner therapy is expressly permitted in 22 states and Baltimore, Md., according to the CDC. Although legally prohibited in eight states, expedited partner therapy is potentially allowable from a legal standpoint in the 20 remaining states, Washington, D.C., and Puerto Rico. The legal basis for expedited partner therapy varies from state to state, but is established through legislation, regulation and modification of state medical, nursing and pharmacy practice laws. In addition, state public health departments issue appropriate care guidelines for clinicians that specify the types of patients and antibiotics best suited for expedited partner therapy as an option for partner therapy.

Since expedited partner therapy allows clinicians to provide prescription medications to people they have not examined, medical providers and pharmacists may believe the practice to be unethical, fear sanctions by state licensing boards or have concerns about malpractice liability. Without specific legislation that endorses expedited partner therapy, providers may be concerned about the legality of the practice.

That said, states have taken different approaches to addressing professional liability related to use of expedited partner therapy. Utah House Bill 17 and Illinois Senate Bill 212, both adopted in 2009, specifically state that medical practitioners who use expedited partner therapy according to the guidelines are not liable for medical malpractice, unless their actions constitute willful or wanton misconduct. In other cases, liability issues are addressed in state guidelines used to educate providers considering use of expedited partner therapy. For example, the California guidelines for medical practitioners state:

“This liability is no different from the liability of any other action taken by a health care provider, including prescribing or dispensing medicine for any medical condition, in which the provider remains liable. However, guidelines establish a standard of care, and standard of care is the primary medicolegal standard for appropriate practice.”

State actions supporting expedited partner therapy are based on recommendations from the CDC. In 2006 the CDC indicated that expedited partner therapy should be available to providers as an option for treating the partners of individuals with chlamydia and gonorrhea infections. Based on expert evaluation of clinical trial results, expedited partner therapy was an effective and potentially cost-saving approach to treating sexual partners and reducing reinfection in diagnosed patients. The CDC’s guidelines for treating sexually transmitted diseases also describe when clinicians should consider using expedited partner therapy in partner treatments. Using expedited partner therapy under prescribed conditions also has been supported by the American Medical Association, the American Bar Association, the Society for Adolescent Medicine, the American Academy of Pediatrics, and the National Association of County and City Health Officials.
Removing legal barriers to expedited partner therapy is one component of a comprehensive state approach to prevent sexually transmitted infections. In a recent survey, the American Social Health Association defined 11 components of state sexually transmitted infections prevention policies, including:

- **Clinical care policies**: Prenatal screening for sexually transmitted infections, expedited partner therapy, opt-out written consent for HIV testing in sexually transmitted infection clinics and mandated sexually transmitted infection-related vaccines;
- **Insurance coverage policy**: Mandated HIV and sexually transmitted infections testing;
- **Reporting policies**: Electronic laboratory reporting for sexually transmitted infections and related conditions, mandated vaccine data storage in immunization registry; and
- **Education policies**: Age appropriate and comprehensive sex education, comprehensive sexually transmitted infection and/or HIV prevention education, certification or training for sexuality and health education instructors, and use of a standardized state-approved curriculum.

The American Social Health Association found many of these approaches, like expedited partner therapy, are not widely adopted and in 15 states, none of the policies were in place. Seven “leader” states—Alabama, California, Hawaii, Illinois, Louisiana, Minnesota and Missouri—adopted at least five of the 11 approaches listed above. The survey also identified removing barriers to expedited partner therapy as one of the top four priorities for policy change in the states.

The ASHA examined state prevention funding for the 2007 fiscal year and compared it to the cost of treatment for sexually transmitted infections. State sexually transmitted infection prevention program spending averaged 23 cents per capita from state sources and 60 cents per capita from federal funds. This prevention total of 83 cents per capita represented less than 2 percent of the $49 per capita spent annually in the U.S. on sexually transmitted infection treatment. Profiles of the American Social Health Association survey results for each state are available at http://www.ashastd.org/stdpreventionfunding/rpt_funding.cfm [7].

The National Chlamydia Coalition is another national effort whose work supports state sexually transmitted infection prevention efforts. The coalition was initiated in 2008 to encourage wider testing for chlamydia and to reduce preventable infertility and other harmful effects of chlamydia among sexually active adolescents and young adults. Comprised of national nonprofit organizations, health care professional associations, advocacy groups, health insurers, and local, state and federal government representatives, the coalition provides resources for clinicians and public information tools to encourage wider interest and support for chlamydia testing and treatment, and more awareness of how to combat this often silent infection and its severe consequences. For more information, see http://www.prevent.org/ncc [8].

**Implications for Future State Health Policy**

As federal and state lawmakers consider expanded health insurance coverage, which will lead to greater use of prevention services, new opportunities exist for reducing the impact of sexually transmitted infections including infertility.

As expanded health coverage increases access to prevention services among previously uninsured populations, other supportive efforts will be needed to increase use of these services. Allowing for full insurance coverage of sexually transmitted disease testing services without copayments and deductibles can eliminate payment barriers for patients. Health department communications can increase public and provider awareness and use of recommended sexually transmitted infection
prevention services. Educating medical providers to perform recommended sexually transmitted infection prevention services for their patients will be more important if publicly-supported services are curtailed. For example Massachusetts, a leader in health access reform, has closed publicly funded sexually transmitted infection clinics in six locations outside Boston since 2008, presuming that those sexually transmitted disease services can be provided by general medical practitioners.34

Health coverage reform should greatly reduce the role that lack of health insurance plays as a cause of health disparities, but other initiatives are needed to connect the previously uninsured with trusted sources of medical care and information about how to manage their sexually transmitted infections. Additional evidence is needed about the success of education, testing and prevention programs on reducing the burden of sexually transmitted infections and their consequences, particularly among African-American adolescents and young adults.34 See The Council of State Governments’ Overcoming Women’s Disparities in Women’s Sexual Health policy brief at http://www.csg.org/pdfs/WomensHealth.pdf [9].

Finally, given broader access to preventive health services under health reform and well-accepted evidence that chlamydia testing is a cost-effective practice, more testing and treatment of patients with chlamydia is anticipated. Since many chlamydia infections are undetected, wider testing will lead to a greater need for sexual partner treatment services, and greater demands on available health department resources. State health department funding continues to be reduced—more than three-fourths of state public health agency budgets were cut in the 2009 fiscal year and nearly 40 percent expected further cuts in the 2010 fiscal year.35 Sexually transmitted infection prevention program funding has also been reduced,36 so health department programs that provide direct services (partner examination and treatment) will not have sufficient resources to respond to the increased demand. Expedited partner therapy could help address much of this anticipated increase in demand for partner treatment. Establishing a supportive legal environment for expedited partner therapy will enable states to implement this cost-effective public health practice, reduce infections and their serious consequences, including infertility.

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Notes


15 Centers for Disease Control, Legal Status of Expedited Partner Therapy (EPT).  

16 Illinois Department of Public Health (IDPH) Sexually Transmitted Diseases Section, “Expedited Partner Therapy for Chlamydia Trachomatis and Neisseria Gonorrhoeae,” Guidance for Health Care Professionals in Illinois, January 1, 2010,  

17 HIV/STD Program, Texas Department of State Health Services. Expedited Partner Therapy (EPT).  

18 New Mexico Department of Health. Expedited Partner Treatment.  

19 Washington State Department of Health. “Sex Partner Treatment of Chlamydia and Gonorrhea Infections,”  

20 Sexually Transmitted Diseases (STD) Control Branch, California Department of Public Health,  
“Patient-Delivered Partner Therapy for Chlamydia trachomatis and Neisseria gonorrhoeae: Guidance for Medical Providers in California,” March 27, 2007,  

21 IDEPC Division, STD and HIV Section of the Minnesota Department of Health, “Expedited Partner Therapy (EPT) for Chlamydia trachomatis and Neisseria gonorrhoeae: Guidance for Medical Providers in Minnesota,” November 2008,  

22 James G. Hodge, Amy Pulver, Matthew Hogben, Dhrubajyoti Bhattacharya, and Erin Fuse Brown,  
“Expedited Partner Therapy for Sexually Transmitted Diseases: Assessing the Legal Environment,”  
American Journal of Public Health 98, no. 2 (February 2008),  


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